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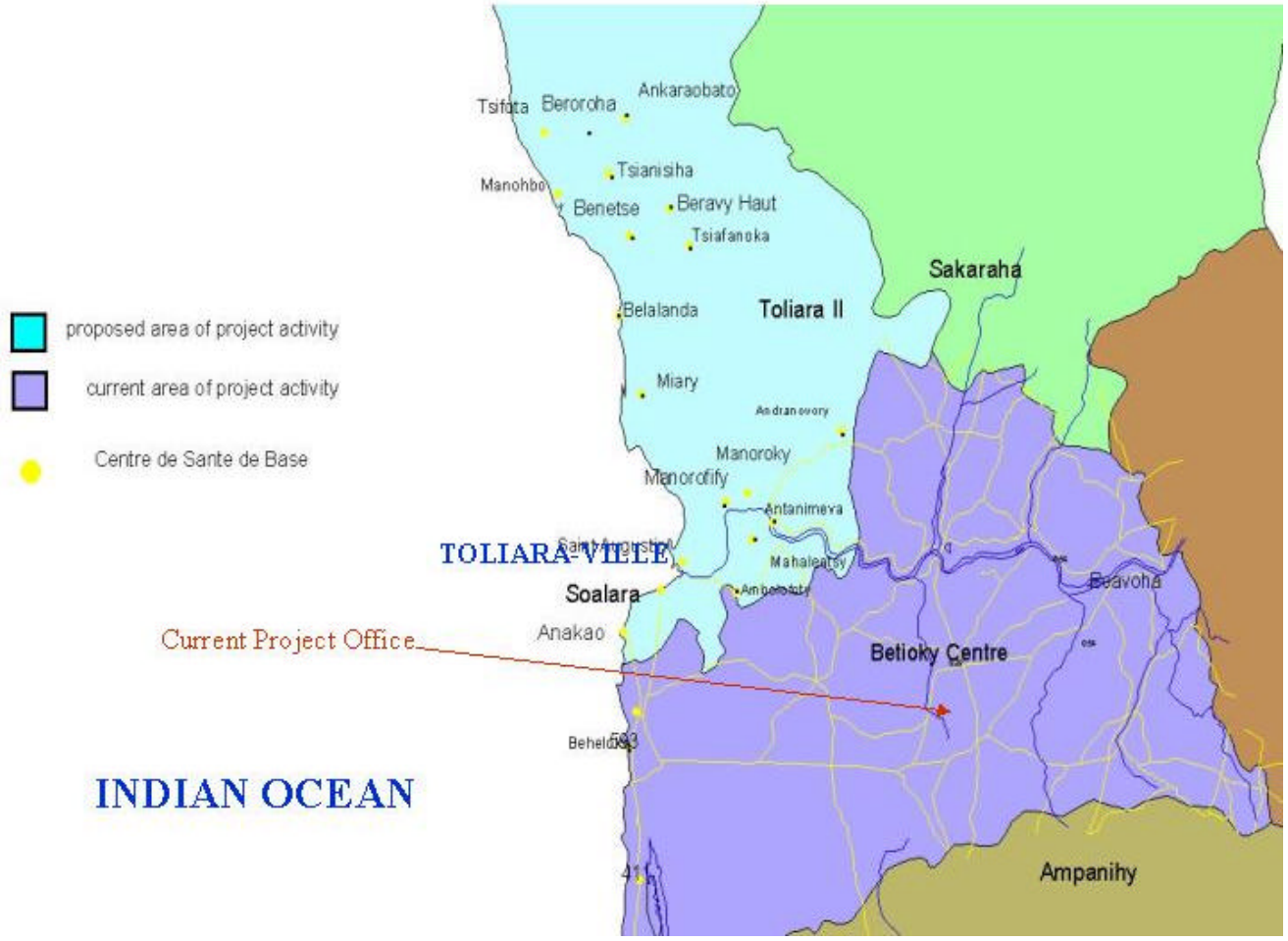
BETIOKY – DISTRICT CHILD SURVIVAL PROJECT

THIRD ANNUAL ACTIVITY REPORT
(English Translation)

(OCTOBER 1, 2000 – SEPTEMBER 30, 2001)



Cooperative Agreement No. FAO-A-00-98-00027-00
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FOREWORD

The submittal of the Third Annual Activity Report follows the submittal of the Mid-Term Evaluation in February 2001 and the cost-extension application in December 2001. The timing of the submittal has been affected by the events occurring during and following elections in the country.

BETIOKY-SUD DISTRICT CHILD SURVIVAL PROJECT

THIRD ANNUAL ACTIVITY REPORT
From October 01, 2000 to September 30, 2001

Cooperative Agreement No. FAO-A-00-98-00027-00

April 16, 2002
(English Translation of Original French Version)

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ACRONYM LIST

AEPE	Child to Child Approach (Approche Enfant pour Enfant)
AGR	Income generating activities (Activités Génératrices de Revenus)
AME	Exclusive Breastfeeding (Allaitement Maternel Exclusif)
ASB	Basic Health Agent (Agent de Santé de Base)
ASBC	Community Health Agent (Agent de Santé à Base Communautaire)
BHR/PVC	Bureau for Humanitarian Response/Private Voluntary Cooperation
BCC	Behavior Change and Communication
BFHI	Baby Friendly Hospital Initiative
BS-CSP	Betioky - Sud Child Survival Project
CDD	Control of Diarrheal Diseases
CISCO	School area (Circonscription Scolaire)
COLC	Operations Committee on fight against cholera (Comité Opérationnelle de Lutte Contre le Choléra)
C-RH	Community Reproductive Health
CSB	Basic Health Centers (Centre de Santé de Base)
CSTS	Child Survival Technical Support
CVA	Village Animation Group (Cellule Villageoise d'Animation)
DAR	Rural Animation Directorate (Direction de l'Animation Rurale)
DIP	Detailed Implementation Plan
DIRDS	Inter-regional Health Development Department (Direction Inter-Régionale du Développement Sanitaire)
DPT	Diphtheria – Pertusis and Tetanus
EMAD	District Health Management Team (Equipe de Management du District)
EPI	Extended Program on Immunization
FP	Family Planning
HMIS	Health Management Information System
IEC	Information-Education-Communication
IMCI	Integrated Management of Childhood Illnesses
KPC	Knowledge, Practice and Coverage
LQAS	Lot Quality Assurance Survey
MAMA	Manabe Aizana ny Mampinono Anaka
MICC	Ministry of Information, Communication and Culture
MINSAN	Ministry of Health (Ministère de la Santé)
MLD	Long Term Method [Family Planning] (Méthode de Longue Durée)
MOU	Memorandum Of Understanding
MSR	Safe Motherhood (Maternité Sans Risques)
MTE	Mid-term Evaluation
NGO	Non-governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PDD	District Development Plan (Plan de Développement du District)
SSD	District Health Directorate (Service de Santé du District)
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant

TIF	Tahiry Iombonanâ Fahasalamana ny Momba (Health Insurance Credit Scheme)
TOR	Terms Of Reference
UERP	Unit for Pedagogic Studies and Research (Unité d'Etude et de Recherche Pédagogique)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United Sates Agency for International Development
VAT	Vaccine Anti-Tetanus
VCP	Peace Corps Volunteer (Volontaires du Corps de la Paix)
VCs	Community Health Volunteers (Volontaires Communautaires de Santé)
VENIMA	Vehivavy Miara-Mandroso (Association of Women Advancing Together)
VISA	Visit, Identify, Sensitize, Attend

1. RESULTS

1.1 Progress towards attaining the technical objectives of the program

As part of the routine project monitoring plan for the Child Survival project in Betioky-Sud District, a KPC survey was conducted in December 2001 using the Lot Quality Assurance method (LQAS). This survey was set-up jointly by Medical Care Development International (MCDI) and the District Health Services for Betioky–Sud and conducted in the villages covered by the project. Each survey was given to 19 mothers of children less then 2 years of age in each health sector area. The survey used 8 questionnaires.

In addition to the information related to project activities (which were obtained by the aggregation of the results per lot), the survey also permitted a comparison of results between health sectors having attained an adequate level of coverage by each intervention or not.

The results of this survey are primarily intended to assess project progress (or lack thereof) in order to improve project implementation.

Breastfeeding Promotion

Objectives	**Progress towards objectives**	**Comments**
Increase from 11 to 25% the percentage of children less than 6 months of age exclusively breastfed.	YES	The sum of results received from the lots has shown that 43.1% (42% in 2000) of mothers with children less than 6 months of age breastfed exclusively.
Increase from 61 to 80% the percentage of children age 0 to 23 months who are breastfed more often than normal when having diarrhea.	YES	The sum of results received from the lots has shown that 75.3% (65% in 2000) of mothers of children age 0 to 23 months breastfed their children with diarrhea more often than normal.
Increase from 29 to 40% the percentage of mothers who initiate breastfeeding in the first hour following the birth of their child.	YES	The sum of results received from the lots show that 43.8% (35% in 2000) of mothers have initiated breastfeeding in the first hour following the birth of their last child.

Extended Program of Immunization

Objectives	Progress towards objectives	Comments
Increase from 9 to 30% the percentage of children age 12 to 23 months fully immunized, according to their immunization card.	YES	The sum of results received from the lots has shown that 26.6% (21% in 2000) of children age 12 to 23 months are fully immunized.
Reduce from 25 to 10% the percentage of children 12 to 23 months who dropped out from vaccination between DPT1 and DPT 3.	YES	The sum of results received from the lots has shown that 10% (7% in 2000) of children ages 12 to 23 months dropout from vaccination between DPT1 and DPT3. There are no significant statistical differences between the two results.
Increase from 21% to 40% the percentage of mothers who have 2 doses or more of the anti-tetanus vaccine.	NO	The sum of results obtained from the lots has shown that only 5.9% (16% in 2000) of mothers have received 2 or more anti-tetanus vaccines. *Note: This result is tied to the low utilization of CPN (Pre-Natal visits) among pregnant women. In fact, during this same study and based on CPN files, only 7% of mothers have had 2 CPN or more. Also, this situation is very similar to what happened in the entire Toliara region.*

Control of Diarrheal Diseases

Objectives	Progress towards objectives	Comments
Increase from 61 to 80% the percentage of children age 0 to 23 months who are breastfed more often than normal when having diarrhea.	YES	**See first box about Breastfeeding Promotion above**
Increase from 53 to 70% the percentage of children from 0 to 23 months having had diarrhea and who received the same or increased amount of liquids.	YES	The sum of results obtained from the lots has shown that 94.1% (61% in 2000) of children less then 24 months of age have received the same or an increased amount of liquids when having diarrhea. *Note: 77% received more liquid and 17.1% the same quantity than usual.*
Increase from 12 to 50% the percentage of mothers seeking for advice or treatment for their child in cases of prolonged instances of diarrhea (more then 14 days) or bloody diarrhea.	YES	An error occurred in the sampling of this indicator and thus the present level could not be measured. In fact, 19 mothers could not be found who seek treatment or advice when their last child had diarrhea in each one of the tested health sector areas. However, results from the MTE in 2000 showed clear progress towards reaching the objectives (59%). *Note: Related to the knowledge of the mothers, the signs*

		motivating them to seek advice or treatment for her sick child were primarily the following danger signs: diarrhea and persistent vomiting (16.9%), persistent hyperthermia (55.2%), refusal of water intake (2.5%), refusal to eat (16.4%), convulsions (2.7%), dehydration signs such as lack of tears, sunken fontanelle (4,5%), lethargy (4.2%).

Birth Spacing

Objectives	**Progress towards objectives**	**Comments**
Increase from 9 to 20% the percentage of non-pregnant mothers who did not want to have another child in the next two years and are using modern family planning methods.	YES	The sum of results obtained from the lots has shown that 16% (15% in 2000) of non-pregnant mothers do not want another child in the next 2 years and are using modern contraceptive methods.
Increase to 25% the percentage of mothers who can name a place where information and advice is given on modern birth spacing methods.	YES	The sum of results received from the lots has shown that 85,9% (56% in 2000) of mothers know of a place where information and advice are given on modern methods of birth spacing. *Note: For this indicator, the survey may be biased as some of the mothers could have been tempted to answer according to the benefits already provided to them through counseling services and free methods of birth spacing.*

In general, the project has achieved success in the overall implementation of the interventions and is progressing towards achieving the objectives defined in the Detailed Implementation Plan (DIP).

1.2 Progress towards Capacity Strengthening Objectives

Different Levels	DIP Objectives	Results until 2001
Project Manager	-Management training -Training of trainers -Updates on Child Survival Techniques -IMCI training -HMIS Design -English training	-Training on IMCI -Program management training -Training on project design with "Entreprendre à Madagascar" - Language training (English language). - Participation on the CORE Group meeting in 1999 - Workshop on Participatory Evaluation/LQAS- Senegal 2000 - Workshop on M&E and Sustainability - Mali 2002
Administrator		-Training on project design with "Entreprendre à Madagascar"
Quality Services Coordinator	-Trainee training -Training on behavioral changes/Updates -IMCI training -HMIS design - Supervision training -English training	-IEC training -IMCI Clinical training and as an IMCI trainer -MEP training (Non-formal) -Language training (English language) -Project management training (Virginia, Washington)
HMIS Coordinator	-Child survival techniques update -Monitoring training -Training of trainers -IMCI training	-AEPE trainer training - MARP method training -MEP training (Non formal) -LQAS method training (Non formal) -Descriptive and inferential statistics training -Training in computer programming (Dbase, Access) -Language training (English language) -Training in project design with "Entreprendre à Madagascar"
Community Activities Coordinator		-Computer training (office) - Language training (English language)
Health Workers (ASBs)	-18 ASBs trained in breastfeeding -18 ASBs trained in CDD -18 ASBs trained in FP -18 ASB trained in EPI -BCC training -Information management training	**Breastfeeding** -20 ASBs and 11 physicians have received initial training in breastfeeding including LAM, counseling practices, MAMA, weaning foods -20 heads of health posts, 5 members in charge of the program, and members of EMAD have received additional training in EPI -20 ASBs and 11 physicians received initial training in national immunization policy -20 Heads of health posts, 5 members in charge of the program, and EMAD members have received additional training in breastfeeding **EPI** -20 ASBs, 11 physicians have received initial training on national immunization policies -20 heads of health posts and 5 members in charge of the program and EMAD members have received additional training -4 members in charge of the program have been trained in training supervision -1 health worker, in charge of EPI/SSD, has received training in cold chain maintenance -450 CISCO teachers have been trained

		FP/RH -30 health staff have been trained in clinical FP (IEC/FP, HMIS/FP, clinical FP, fight against STIs/AIDS) -11 ASBs have received training in the establishment of ASBCs -30 ASBs have been trained in integrated reproductive health -17 health staff were trained in safe motherhood using the 3A method (Self-learning) -3 physicians were trained in MLD (Long-term method) of family planning (Implant) **IMCI** -14 health staff were trained in clinical IMCI using the classical training method -11 physicians and 7 EMAD members were introduced to clinical IMCI using the 3A method -7 health staff members who have received the classical training were re-trained
SSD Staff members	-Technical clinical training in Child Survival -Training in BCC -Supervision training -Information management training	-Training of 3 SSD program coordinators in basic IEC techniques -Training of 4 SSD program coordinators in supervision -Training of the EPI coordinator in cold chain maintenance -Training in the participatory evaluation method
Community Associations		**Community Credit Insurance** -Training of office members in management (management of the association, management of funds, and use of management tools) and monitoring of the community credit insurance **Community Volunteer Associations** -Training of 8 community-based associations in the creation of community associations -Training of 3 Community Volunteer Associations in the creation and the management of and income-generating activities (IGA) **Associations/Local NGOs** -Training of 15 VEMIMA members in the creation of associations -Training of 3 VEMIMA members in community-based Integrated Reproductive Health -Training of 15 VEMIMA members in basic techniques of communication and messages on Child Survival (EPI/FP, Breastfeeding, Home care of diarrhea, Safe Motherhood)
Community Volunteers	-Training in IEC-social mobilization technique -IEC and social mobilization update -142 VCs trained on breastfeeding -142 VCs trained on FP -142 VCs trained on EPI -142 VCs trained in home care for diarrheal cases	-Training of 268 VCs in TBC -Training of 249 VCs in maternal breastfeeding, including exclusive maternal breastfeeding -Training of 233 VCs in FP -Training of 207 VCs in EPI -Training of 268 in Diarrhea (promotion CDD and cholera, home care of diarrhea cases) -Additional training for 167 VCs previously trained on the 4 themes -Quarterly supervision of 193 VCs -Monthly meetings of 8 CVs associations -Training of 85 ASBCs in TBC, messages for promoting birth control, and on management of community-based distribution sites for contraceptives -Additional training to 40 ASBCs

1.3 Progress towards sustainability objectives

Goals	Objectives	Progress towards objectives	Comments
VCs will become agents of change	- Trained VCs will ensure promotion of beneficial health behavior in the villages -Positive community response to education, advice and promotion by the VCs	YES	-249 VCs trained in breastfeeding, 207 VCs trained in immunization, 268 VCs trained in CDD, 223 VCs trained in promoting birth spacing, and 85 community agents distributing contraceptives -VCs attrition rate of less then 7% since the beginning of the project -8 VCs groups formally legalized as associations -Each VCs association prepares and executes its own activity plan, and follow-up plan with the support of the commune and of the Rural Animation Delegation -Each volunteer allots a minimum of 4 hours per week for the volunteer health promotion work -Behavioral changes are observable at the population level (*See: table on the progression towards technical objectives*) -Volunteer incentive initiatives using revolving funds were put in place. 3 Associations are implementing income-generating activities -The Commune has begun to support VCs activities through the creation of a Community Health Committee, which coordinates the activities and has created a specific budget line item to support those activities
VCs mobilize the communities so that they seek quality CS services	-VCs set up a community follow-up system to permit tracking of people who drop out of the immunization program and which encourages mothers to support child survival interventions -VCs will advise community care providers on issues including risks, danger signs and good practices for children less	YES	A new social mobilization approach was adopted to reinforce the already existing VISA approach -The community reference system (reference for diseases and EPI) is operational in 2 health districts -Social mobilization events are regularly held in collaboration with local authorities and the community -Regular meetings between VCs and village support groups -ASBCs ensure FP promotion and the smooth

	then 2 years of age. - VCs and CSB staff support the utilization of the referral and counter-referral system		functioning of FP community sites
SSD and CSB respond to quality care demands	-Continued in-service training strengthens health staff performance in the CSBs -SSD has implemented a regular mechanism for re-stocking essential medicines and medical supplies -SSD Personnel is adhering to quality performance protocols	YES	-31 health personnel were trained in breastfeeding, 36 in EPI, 32 in IMCI, 30 in FO and 4 in long-term contraceptive methods (implants). The training post-test and the follow-up have shown increased knowledge and skills in these personnel and on case management. All training sessions followed the MOH prescribed modules and protocols. -Coordinators of training programs provide periodic and systematic refresher training to health staff -Viable drugs stock system in place with a cost recovery system. 100% of the CSBs had an adequate stock of essential medicines in the 6 last months. -Case management algorithms are applied -EMAD has prepared and is executing the supervision plan. Competence of supervisors still needs to be resolved. Supervision tool, designed and utilized jointly with the EMAD team, is based on an evaluation of skills strengthening of the health personnel in place
Communities are supporting the co-financing scheme of health services	- Communities support an equitable approach to co-financing based on pilot testing -Pricing policy for drugs and services are child survival friendly -SSD develops their capabilities in financial management and planning to support community cost recovery efforts	YES	-A pilot health insurance credit scheme was tested, is viable and functioning and ensures access to quality care at all times. The participation rate is more then 80% of the population and the non-reimbursement rate is minimal. The CSB utilization rate has increased. A study on replicability is in course. -Subsidized prices for ORS have been applied

1.4 Results at the end of fiscal year 2001 as compared to programmed activities (Table B - DIP)

1.4.1 Breastfeeding Promotion

MAIN INPUTS PROGRAMMED UNTIL THE END OF THE PROJECT	RESULTS at the end of 2001
Training of 18 health staff in the areas of promoting breastfeeding including the benefits of exclusive breastfeeding; counseling; LAM and weaning foods CSB staff sensitization on Baby friendly Hospital Initiative (BFHI) & MOH protocols Selection & training of 142 health volunteers in breastfeeding promotion Establishment of informal breastfeeding support groups Participation of matrons/midwives, traditional healers, religious leaders etc. in breastfeeding promotion Strengthening the supervision of health staff and volunteers through visits, direct observations of counseling sessions and feedback from mothers Adaptation and dissemination of breast-feeding promotion messages	31 service providers received initial training in breastfeeding promotion The project has supported the Baby Friendly Hospital Initiative in 2 Betioky-Sud District Hospitals, through the training of 6 health staff, and periodic follow-up and the publication of posters on BFHI 249 community volunteers were trained in breastfeeding promotion and now offer community counseling services 5 support groups have been identified (As for the strengthening the supervision of health staff personnel, see Section on immunization) Steady supply of health education materials from partners and the MOH. The project has decided that it would be preferable to first test the efficacy of available visual materials; as such, it is not yet necessary to produce new ones. Development and dissemination of audio messages on rural radio[1] The message on breast-feeding practices for newborns was adapted to reach a consensus traditional family attitudes and practices and the recommended breastfeeding practices Dissemination of child to child approach in all primary schools of Betioky-Sud (140 public and 14 private schools) with training of more then 450 teachers on breastfeeding promotion Establishment of an Inter-sectorial Support Committee Establishment of income-generating activities as a source of incentive for volunteers at 3 sites Legal establishment of 8 volunteer groups as legal autonomous associations

[1] Record audiotapes and disseminate information on family experiences, facts, and accomplishments. These materials were distributed through a network of listening points for collective listening sessions.

1.4.2 Extended Program of Immunization

MAIN INPUTS PROGRAMMED UNTIL THE END OF THE PROJECT	RESULTS at the end of 2001
Strengthening the cold chain in 11 health facilities in coordination with UNICEF and the MOH	19 out of 20 Betioky-Sud SSD health facilities have an operational cold chain
Initial and follow-up training of 18 health personnel and supervision in EPI protocol, vaccine management, cold chain maintenance, missed opportunities, recoveries (EPI policy)	100% of the centers equipped with refrigerators have had regular kerosene stocks in the last 6 months, due to the re-organization of the stocking system 36 ASBs have received initial training in EPI according to the new EPI policy of the MOH
Selection & training of 142 health volunteers in immunization promotion, followed by surveillance at village level.	25 ASBs have been re-trained in immunization 207 VCs have received training in immunization promotion
Establishment of a reference system between health volunteers and health centers, including a double entry recording system in order to track dropout cases	2 health sector areas have established a reference system between VCs and CSBs (Ankazomanga et Antohabato) Joint creation (EMAD/MCDI) of a Health Center Supervision Tool
Adaptation and implementation of appropriate strategies in social mobilization and IEC	Training of 4 program coordinators in formative supervision and supervisory tools
Strengthening SSD supervision capacity to ensure follow-up and a framework for covering quality immunization services	Re-organization and operational planning of district supervision, taking into account the supervision hierarchy, the form of supervision, and the long and short-term resources of the SSD Supporting effective supervision from direct participation, strengthening of transport capacities (motorcycle repairs and vehicle support), the supply of supervision forms and incentives to the supervision team Implementing the child-to-child approach in 154 primary schools with the training of over 450 teachers in immunization promotion Implementation of an Inter-Sectorial Support Committee

1.4.3 Control of Diarrheal Diseases

MAIN INPUTS PROGRAMMED UNTIL THE END OF THE PROJECT	RESULTS at the end of 2001
Improvement in the stocking of ORS as well as IV fluids in all of the health centers in the project area	Technical and logistic support to the MOH cost sharing program in order to improve the availability of essential medicines in the health centers (support in implementing the program and providing vehicle support)
Initial training, in-service training and supervision of 20 health staff in diarrheal case management as per MOH protocols	14 health staff trained in IMCI protocol according to the national protocol
Selection & training of 142 health volunteers including matrons/midwives and traditional healers in home-based care and for cases of diarrhea, the evaluation and referral of complicated cases	Training using the assisted self-learning method of 18 service providers in IMCI protocol (in progress) Training of 268 health volunteers in home-based care for diarrhea using ORT, recognition of danger signs, referral and prevention.
Promoting community distribution of ORS packets at affordable prices	Adaptation and implementation of a behavioral change communication strategy based on input from health volunteers, schools, support groups and local authorities. Development of IEC audio material using live testimonies, sketches, presentations and "spots."
Adapting and implementing appropriate IEC and social mobilization strategies to control diarrheal disease	Dissemination of IEC materials on diarrhea and incorporating the essential CDD messages (advice card, posters, publications, advertisements, audio tapes, pennants, etc.)
Explore the possibility of introducing solar ovens for sterilization of drinking water	Implementing the child-to-child approach in 154 primary schools through the training of over 450 teachers in CDD promotion Establishment and operation of an Inter-sectorial Support Committee Community-based promotion of ORS as well as exploring the possibility of introducing solar ovens have not yet occurred

1.4.4 Family Planning

MAIN INPUTS PROGRAMMED UNTIL THE END OF THE PROJECT	RESULTS at the end of 2001
Initial training of 12 ASBs in birth spacing services, IEC - FP, HIS-FP. Ensure stocks of contraceptives in 12 health centers in the project area Selection & training of 142 health volunteers in birth spacing promotion Adaptation and dissemination of messages as well as social mobilization strategies on birth spacing methods: (1) 142 VCs will be able to identify potential new users; (2) targeting the prevention of adolescent pregnancy through appropriate IEC activities; (3) targeting husbands, grand-mothers and mothers-in-law and explaining the benefits of birth spacing methods; (4) development and implementation of a low-cost incentive system to help the ASBs and VCs to promote birth spacing Scaling up the community-based distribution of contraceptives and condoms Extend FP services to the private medical sector Implement a strategic planning workshop with key staff of the MOH to increase support to child spacing interventions	All 20 CSBs of the SSD of Betioky provide FP services and are equipped and managed by trained personnel (15 new sites opened) 30 health staff received initial training in FP according to MOH protocols 11 heads of CSBs in the project area were trained as trainers of community-based distribution agents The FP Head of SSD was trained as clinical FP supervisor of the SSD. However, she was transferred out of the district. 100% of the CSBs in Betioky-Sud District have an adequate stock of contraceptives in the last 6 months 233 VCs trained and operational in promoting birth spacing (benefits, messages, targeting influential people and vulnerable populations, follow-up on drop-outs) 85 ASBCs (Community-based distribution agents) were trained in community-based distribution. Only 40 of those ASBCs are still working. 10 out of 20 health sectors of the SSD Betioky-Sud District have functional community-based distribution sites 4 SSD personnel have been trained in long term contraceptive methods (Implant)

1.4.5 Credit Insurance Scheme

In the context of operational research and to improve the financial accessibility of the population to resources available to cover costs associated with the cost recovery scheme of the MINSAN, the credit insurance scheme represents one solution for better organization and the direct sharing of cost by the community.

In 2001, it was noted that in the pilot area community, familiarity with this financing scheme has resulted in a level of understanding that has permitted community members to feel comfortable and involved with this form of community financing. However, prior to the end of the project, there should be a transfer of skills over to community leaders to ensure better sustainability of the community credit scheme.

It should be noted that the closing of the health center from April through October 2001 (due to a conflict between health agents and the community), resulted in a drop in the utilization of credits and the number of consultations.

With assistance from the Director of monitoring and operational research from the staff of the DIRDS (Inter-regional Health Development Department) and the Secrétariat Général of MINSAN, the project presented a report detailing the results of the evaluation of the first year of the credit scheme at the University of Antananarivo and the MINSAN. Feedback on the report favors duplication of the scheme and further suggests the possibility of duplication at the national level so that the MINSAN can better recover costs. However, duplication of the credit scheme should be sensitive to the recommendations presented in the Mid-Term Evaluation.

The project has reinforced the capability of the community management committee members through periodic monitoring and refresher training in funds management.

2. FACTORS CONTRIBUTING TO PROJECT RESULTS

2.1 Improved collaboration between SSD and MCDI

The Mid-Term Evaluation underscored collaboration as a priority to be addressed by MCDI during the next two years of project implementation. Thus, the collaboration between the SSD and the project improved quite a bit during fiscal year 2001. In March 2001, a team-building workshop was held, followed by a planning workshop with the SSD, in collaboration with the DIRDS and the USAID Mission, to strengthen the partnership between the SSD and MCDI. As a result of these workshops the following was achieved:

- The working agreement between the MINSAN and MCDI was reviewed and approved
- The action plan for the child survival project in Betioky was integrated into the District Development Plan, as an essential condition for the involvement of the district in the implementation of the project.
- A framework implementation plan outlining all technical and organizational aspects salient to the project's implementation was reviewed and approved. This document serves as the official working document defining respective MINSAN and MCDI roles and

responsibilities. Further clarification of the responsibility of the EMAD as well as for the SSD was also forthcoming as a result of the meetings. Improved collaboration has led to increased EMAD and SSD involvement in the project and has led to improved project coordination.

2.2 Continued DIRDS Support

The DIRDS has played a major role in improving collaboration between the SSD and MCDI by facilitating policy dialogue and sponsoring agreements between the two parties (technical implementation document). It has also played an important role in solidifying these agreements through regular follow-up site visits and by organizing periodic progress review meetings. In addition, the DIRDS participated in the two team-building and planning workshops in March 2001. The DIRDS has always remained involved in problem solving, whether related to technical issues or relational problems at all levels (community, SSD, local authorities).

Program management capability of the SSD staff has also improved due to the DIRDS technical support, through the establishment and monitoring of SSD indicators and through the organization of quarterly review meetings with the SSD and the entire staff (heads of programs, heads of posts, providers, and administrators). These efforts have led to an improved district development plan, which integrates CSP activities.

2.3 Strengthened partnership with the Rural Animation Delegation (Délégation de l'Animation Rurale, or DAR)

The DAR has contributed to the attainment of project results due to its involvement in the project's community activities. As mentioned in previous annual reports, the Department of Information has detailed one of its staff members to assist the project in the implementation of its community-based activities. Previously, this person worked part-time for the project (3 half-days per week); this has now become full-time job as of 2001. This person is in charge of Health Education for the project and she coordinates and implements her work in collaboration with the IEC Head of the SSD. This relationship has made a positive contribution to the improvement of knowledge and practices of the population. It is also important to note that this situation facilitates the progressive transfer of responsibility from the project to the DAR.

2.4 Peace Corps Volunteer Support

The Peace Corps Volunteer (PCV) plays a very active role in the implementation of project IEC activities by assisting the Health Educator. The PCV has been central to the monitoring of all community-based project volunteers, as well as for the development of social mobilization activities such as the VISA method and development of management tools for community activities (i.e., training modules, supervision, and planning tools). The PCV has truly reinforced and assisted the MCDI team.

2.5 Increased Involvement of Local and Community Authorities

Following the presentation of the MTE's results, which outlined project progress as well as areas in need of improvement, community and local authorities have renewed their enthusiastic

support for the project. A sense of local responsibility and ownership has increased. Thus, local authorities have begun to take a more active role in social mobilization and in supporting health volunteers (logistically, financially, and/or institutionally). Communities have become more responsive to BCC initiatives and participate a little more in these activities (i.e., the VISA approach). As a result, volunteer motivation has improved and the organization of volunteers into formal associations has translated into a heightened sense of responsibility. Relying on the project's support, each association has developed an action plan to achieve its objectives, for example, to improve the health status of mothers and children. The managing members of each association are themselves accountable for monitoring implementation and supervision of its members. This aspect is a positive indicator of the sustainability of the project.

The implementation of VISA approach (Visit, Identify, Sensitize, Attend) has permitted a close monitoring of a specific, target population as well as intensive social mobilization with little need for external inputs. This approach has invigorated VCs activities and created accountability within the targeted population, thus leading to renewed motivation in the community (see page 35 for a discussion of VISA).

2.6 Efforts for Sustained Supervision of the CSBs

Positive results have been obtained in the area of strengthening supervision in fiscal year 2001. It has led to improvement of health services at the CSB level, which in turn has translated into a reduction in ruptures in service (i.e. lack of immunization sessions) and a quantitative improvement in health services. Improvements in supervision have resulted from better coordination in programming and resources between the project and the SSD. As a result, the SSD has been able to better respond to the needs and difficulties encountered by the CSBs and has been able to promote CS activities with the CSBs and the community at-large.

2.7 Regular Monthly District Review Meetings

The project made a special effort to establish monthly progress review meetings with the heads of the CSBs. These meetings create a venue for presenting new feedback, updates of health personnel, monitoring, and activities planning in the health centers. These meetings have clearly enhanced SSD's management so that it is more in line with the District's development plan, which includes a CS component.

2.8 Efforts for Strengthening Capacity of Program Heads (FP/EPI)

Since the mid-term evaluation, MCDI has increased its efforts aimed at strengthening the management capabilities of SSD program directors in managing health programs under their supervision. These efforts have greatly improved directors' knowledge of child survival, as well as the implementation of a District Development Plan supportive of the project's program.

2.9 Improvement in Logistics

The purchase of a second car has enhanced the implementation of project activities. In addition, this purchase has made it possible to support the SSD in: (1) transporting essential medicine and

essential supplies (vaccines, petrol, and contraceptives) to the peripheral CSBs and (2) implementation of immunization activities (mobile vaccination points). The acquisition of new computers has ensured the continued smooth operation of the project's HMIS.

3. CONSTRAINTS AND PROPOSED SOLUTIONS

3.1 Decrease efforts based on a multi-sectorial approach

Due to a strategic reorientation concerning the collaboration between MCDI and the SSD, the state's creation of different agencies to battle cholera, i.e., the COLC, the project's intersectorial committee was placed under the control of the COLC. The COLC is principally charged with coordination of cholera prevention activities, which have become a top priority for the District. As a result, project efforts have diminished in the area of coordinating a multi-sectorial approach. A reduction in effort is also linked to a change in personnel at the Sous-Préfecture and in particular, the Sous-Préfet, who, in theory, is the coordinator of the intersectorial committee.

With the help of its partners and implicated actors, the project foresees a return to the multi-sectorial approach in order to ensure the sustainability of CSP activities, involving, of course, the new Sous-Préfet in the committee.

3.2 Modification in the training strategy of the MINSAN

Since 2000, MINSAN has abandoned the classical or traditional training approach which involves group training at a specific time and location in favor of self-teaching which is an auto-didactic method (3A approach - auto-apprentissage assisté) based on modules and tools specifically designed for the method. Training sessions based on classical training methods are no longer permitted for health personnel.

The duration of the training (a 4-month minimum for each theme, i.e., reproductive health), the waiting period for new modules, and the introduction to the 3A approach have slowed down the training time for health personnel. In addition, MINSAN's policy concerning the deployment of health personnel has resulted in the transfer of project-trained personnel and the arrival of new, non-trained personnel.

Thus, the project has been forced to adjust its training strategy by adopting the current MINSAN methodology. The project has become responsible for the monthly progress meetings at the District level and has reinforced its support to CSB supervision to ensure the re-training of new personnel and a framework for training personnel. This has translated into an adjustment of the training budget. Further, the adoption of IMCI by the MINSAN has forced the project to be involved in the implementation of this approach in its entirety.

3.3 Turn Over of Health Directors

MINSAN's policy on the placement of physicians in each commune has modified the existing duties of the already existing CSB health personnel. Duties previously assigned to the Director of each Health Center are now the responsibility of newly recruited physicians. Staff changes and the subsequent orientation period created a rather long transition period and slowed project activities. The same delays can be evidenced due to the redeployment of CSB personnel (nurses, midwives, health aids, health assistants).

3.4 Sustainability of the Child to Child Approach after MCDI Departure

As soon as the Child to Child approach (approche Enfant pour Enfant or AEPE) was adopted, the project decided that the active participation of the school district (CISCO or Circonscription Scolaire) was needed to implement the program at each school. As such, CISCO's trainers, who have been trained by UERP technicians and MCDI staff, are responsible for the training component of AEPE. CISCO has subsequently trained all the Sous-Préfecture of Betioky Sud in the AEPE approach.

With the technical support from the project coordinator of the operational research, members of CISCO created a plan, which covers monitoring, supervision, and refresher training for teachers. Monitoring and supervision tools were created in order to facilitate the job of supervisors in this area. These supervisors have established group monitoring, re-training for teachers, and supervision at several schools.

Because of reservations concerning the sustainability of activities in this particular approach, a collaborative agreement was created between CISCO and MCDI in order to detail and define the roles and responsibilities of each party in the implementation of the AEPE approach. This agreement stipulates that MDCI acts as a supportive agency (largely technical) and that CISCO is responsible for the monitoring, supervision, and re-training of actors, especially the teachers.

In 2001, CISCO exhibited a certain lack of motivation that led to a decrease in activities related to the Child to Child approach in the areas of monitoring, supervision, and re-training of teachers. This lack of motivation was attributed to an under-appreciation by the Directors of CISCO in regards to the ownership and importance of accountability vis-à-vis the approach methods. Therefore, in order to improve the situation, the project held a meeting to update the existing collaborative agreement. The departure plan for the MDCI project will be formally developed with Directors of CISCO.

3.5 ASBC loss of 50% of revenue generated by contraceptive sales

According to initial text of the MINSAN, community health agents, or ASBCs (agents de santé à base communautaire) would get 50% of the income generated through the sale of contraceptives. However, the introduction of the Financial Participation of Users has led to 2 changes since the original plan: (1) the inclusion of contraceptive products covered by cost recovery; and (2) the restructuring of the stocking system of ASBCs (payment for each placed order). Therefore, the initial text is no longer valid and the ASBCs can no longer profit from the sale of contraceptives

(50% of the receipts) as a natural incentive. Furthermore, it is more difficult for ASBCs to have access to contraceptive products, as they must pay in advance for needed contraceptives. This situation, as well as the prolonged transition period created with arrival of new physicians, has resulted in decreased enthusiasm on the part of ASBCs.

4. TECHNICAL SUPPORT RECEIVED DURING 2001

4.1 Credit Insurance Fund

Technical support received for the pilot community credit scheme has focused on improving monitoring tools, a first year evaluation of the credit insurance scheme, and the preparation of a report which presents the results of the evaluation.

Technical assistance was provided by the DIRDS team, the MINSAN, in particular from the Secrétariat Général, and MCDI's Health Economist, Dr. Chris Schwabe.

4.2 Methodology of the 3A approach or assisted self-learning

Since 2000, the MINSAN has modified its training policy. Classical or traditional training required gathering all participants in a specific area and resulted in periodically long absences of health agents from their posts. Realizing the importance of the continuity of service for users, the MINSAN concluded that it was crucial to change this situation while still ensuring training and the coaching of health personnel.

The 3A approach (assisted self-learning method) is based on modules designed for this method. EMAD members and the community physicians first receive orientation from the DIRDS team in the supervision of the method. They in turn, ensure continuous training of health agents (nurses, midwives, health aids).

The training follows a three-step framework:

- The first step defines the 3A approach and the essential points of the modules to the health agents
- The second step, conducted by the EMAD and the DIRDS teams, raises problems encountered by the trainee, solutions, suggestions and ensure practical training. This second step can be accomplished during monthly reviews.
- The third step involves the participation of the EMAD, the DIRDS and the central team. A final evaluation occurs and the trainees receive certification.

The 3A approach has the following advantages: (1) the permanent presence of health personnel in health facilities; (2) training followed by immediate practice in the work area; (3) continued training support.

In 2001, the 3A method was applied to the safe motherhood training. In regard to IMCI, the training is in the planning phase.

5. CHANGES IN THE DIP

5.1 Changes to initial objectives

Indicators	Initial Objectives	Final Level 2000	New Objectives
Percentage of children age 11 to 23 months completely immunized, as evidenced on their medical card	Increase from 9% to 30%	21%	No changes
Percentage of children age 12 to 23 months dropping-out between DCT1 and DCT3	Decrease from 25% to 10%	7%	Maintain at 7%
Percentage of mothers who received more than 2 does of VAT	Increase from 21% to 40%	16%	No changes
Percentage of children less than 6 months of age exclusively breastfed	Increase from 11% to 25%	42%	Reach 55%
Percentage of children age 0 to 23 months who were breastfed more often than normal when having diarrhea	Increase from 61% to 80%	65%	Reach 75%
Percentage of mothers who breastfed their child within the first hour of birth	Increase from 29% to 40%	35%	Reach 45%
Percentage of children age 0 to 23 months who received more liquid or at least the same amount as usual when having diarrhea	Increase from 53% to 70%	63%	No changes
Percentage of mothers needing advice or desiring treatment when their children suffer from prolonged diarrhea (more then 14 days) or diarrhea with blood	Increase from 12% to 50%	59%	Reach 70%
Percentage of non-pregnant women, not desiring a child within the next 2 years, using a modern birth control method	Increase from 9% to 20%	15%	Reach 25%
Percentage of mothers who are aware of a family planning site offering advice on modern methods of birth spacing	Increase of 25%	56%	Reach 70%

5.2 Training of health personnel

Since 2000, MINSAN has abandoned the classical or traditional training which involves group training at a specific time and location in favor of self-teaching which is an auto-didactic method (3A approach—auto-apprentissage assisté) based on modules and tools specifically designed for the method. The modules contain tests, a help manual and the contents of the course. Since 2000, classical training of health personnel has been forbidden. This decision has lowered the number of personnel trained, as each training module requires a fair amount of time to complete (a minimum of four months per theme, i.e., reproductive health). Also, it was necessary to wait for the development of new modules from the MINSAN. The MINSAN's policy concerning the deployment of health personnel has resulted in an almost total transfer of project-trained personnel and the arrival of new, non-trained personnel.

These two factors resulted in the project reorienting its training strategy by: a) adopting MINSAN's strategy for training health personnel; b) at the district level, taking over the monthly review as a means for refresher training and providing a framework for trainers; c) reinforcement of support for the supervision of the CSBs; and d) an upward adjustment of the training budget.

The adoption of IMCI by MINSAN has forced the project to take over responsibility for its implementation in its totality.

5.3 Project site

The project was expanded to cover the entire health district of Betioky Sud. This new area has 20 Health Centers (12 in the old area). This decision was made as a result of the MINSAN's request to reduce equity issues in the project area. This formal recommendation was addressed to MCDI after a project evaluation visit by the Director of the Family Health Service. In order to make this change in the project area, MCDI developed an approach for an extension for the entire project consisting of 2 phases. Phase 1: (2001) support of health facilities including training of health personnel. Phase 2 (2002): extension of project support by establishing and training the VCs. This second phase is largely conditioned on the availability of resources as well as the possibility of collaboration with partners (DAR, VEMIMA, UNFPA, UNICEF).

6. MID-TERM EVALUATION, RECOMMENDATIONS AND ACTIONS TAKEN

6.1 Institutional Memory

Recommendation 1: The main partner, MINSAN, should be present for the rest of the project.

Response: The CSP and the Regional Department of Health have agreed to establish a written, official service memorandum, that is updated at all health levels on a regular basis in order to reinforce the institutional memory and the continuation of services. This memorandum must be the principal tool for the transfer of services between entering and departing personnel. The project has begun to introduce this new system at the District Health Office of Betioky Sud.

It is to be noted that currently, MINSAN policy on personnel rotation still remains in effect, is still very centralized, and not influenced by MCDI or DIRDS. MCDI's discussions with DIRDS have suggested that the region has some latitude in further modifying this policy in the present context of decentralization. Further, the region has affirmed its willingness to maintain some stability in the personnel of MINSAN, if this is part of their new areas of responsibility.

Recommendation 2: Re-evaluate and re-negotiate the partnership between the project and the SSD.

Response: A new SSD organogram was created following negotiations between the project and the SSD since the mid-term evaluation. This organogram demonstrates the functional relation

between the two parties and reflects the creation of one team for the implementation of the project. The agreement protocol (MOU) between the SSD and MCDI was revised, amended, and signed under DIRDS sponsorship.

During a team building and planning workshop held during the month of March 2001, the project activities and strategies were incorporated into the development plan for the Betioky Sud District. In addition, a quarterly operational action plan was jointly established and implemented. A monthly review and monitoring meeting has occurred since July 2001.

All of these steps have truly improved the relationship between BS-CSP and SSD and have facilitated ownership of the project by the main partner. One must, however, note the tremendous support given by the DIRDS and USAID/Madagascar in the resolution of this problem.

Recommendation 3: Establish health centers at the center of community activities.

Response: The BS-CSP and the SSD have decided that the communes are better equipped for making this decision. The project will act in a support role. A workshop to express their grievances was organized to discuss this issue with 19 communes of the district participating, so that local authorities take responsibility.

Recommendation 4: Develop supplemental partnerships with and between community organizations.

Response: No action taken at present.

Recommendation 5: Increase social mobilization and pressure local and community authorities to take responsibility for the project.

Response: The BS-CSP has begun refresher training for communicators (VCs, ASBCs, ASBs) focusing on the deficiencies found during the MTE. The training modules were revised to redress these deficiencies.

The BS-CSP re-evaluated its level of coverage at the community level concerning social mobilization and BCC. The VISA approach was developed and established to reinforce activities and the coverage of volunteers. This approach will be sustained.

Following meetings between BS-CSP and local authorities (communes), the latter has approved an action plan proposed by MCDI, which includes the creation of a budget line for the VCs in the commune's budget, the creation of a health and IEC unit in the commune which will manage the VCs and health activities, train this unit in order to successfully play its role, and acknowledgement of VCs as a complete and useful entity for health development.

Recommendation 6: Evaluate and consolidate the project's successes by encouraging the institutionalization of community partnership organizations, by reinforcing the inter-sectorial approach, and by capitalizing on the success of the credit insurance scheme.

Response: All of the VC associations have been formalized and have begun independent child survival activities and strategies to generate funds.

Recommendation 7: Promote awareness of project success and innovations, such as the community insurance scheme, through presentations and workshops. Thus, increasing the possibility of duplicating the project's initiatives in other regions of the country.

Response: MCDI participates in the quarterly regional meeting (meeting of all SSD personnel of Toliara) in sharing lessons learned, innovations and successes of the BS-CSP. As the BS-CSP is the leader in the area of health community development in the Toliara region, DIRDS has requested that MCDI support the region and other SSDs in the establishment of the HH, C-IMCI and C-RH.

MCDI has begun preparing documentation and disseminating lessons learned.

Recommendation 8: Transfer ownership of activities and results to partners and the community.

Response: Actions in this area have been integrated with other objectives.

Recommendation 9: Use results of the MTE to review project indicators.

Response: The MTE results have led to a revision of the SSD Development Plan. The project indicators have also been reviewed.

Recommendation 10: BS-CSP should cover the entire district, instead of a part of it.

Response: The DIP recommended that the project must involve all of the services of the SSD. Community activities still need to be extended. The BS-CSP, with VEMIMA and MICC, has started to expand its area of coverage to include all of the SSD. MCDI will explore the possibility of collaboration with UNICEF and UNFPA to reinforce this activity.

Recommendation 11: Align the project according to MINSAN guidelines on IMCI and RH.

Response: The BS-CSP is currently working in the areas of IMCI and RH (in part). The DIP mentions the flexibility of MCDI's approach in handling IMCI but not for RH. As such, difficulty arises for the BS-CSP in establishing RH and its partnership with the regional UNFPA.

6.2 The Pilot Health Insurance Credit Scheme

Recommendation 12: It is important to review the studies on duplication of the credit insurance scheme in light of expansion to other sites and possibly other health districts.

Response: A document providing evidence on preliminary results was produced by MCDI in collaboration with the Faculty of Medicine of Antananarivo. The report has largely been disseminated to the Directors of MINSAN to allow them to provide their inputs and comments for the follow-up initiative.

The project has also benefited from the technical assistance provided by Dr. Christopher Schwabe, MCDI's Health Economist, in the elaboration of a final evaluation protocol, as well as for a study of its replicability.

Recommendation 13: (In relation to improving the system's performance) The 3 following steps must be considered as priority for the project:

1 Establish a follow-up plan and re-train management committee members on TIF
2 Review TFI management procedures and amend a few articles
3 Introduce activities on sensitization to health messages to TIF members

Response: After miscommunication between the community of Ankazomanga Ouest, where the pilot scheme has been implanted, and its CSB Head, which appeared in March 2001, the CSB of Ankazomanga Ouest has been closed until now and is awaiting resolution on the SSD's decision to replace the Head of the Center. This situation has not allowed for the implementation of these recommendations.

6.3 Relationship with the SSD

Recommendation 14: A true partnership between the SSD and MCDI constitutes a major challenge for the sustainability of the project. An effort must be made by the SSD to assume ownership on activities of the project, which is supposed to play an integral major part in its action plan (PDD). The functional and hierarchical relations between MCDI and SSD must be clarified. As such, MCDI will maintain its position as an organization supporting development of the SSD and the SSD will be the responsible owner of the project. The CSP should, in any case, have its place on the SSD's organogram.

Response: Based on results from the mid-term evaluation, MCDI has conducted a team building and planning workshop in March 2001 on the CSP, after which a Technical Implementation Document for the project was jointly reviewed and approved by SSD, the DIRDS, and MCDI and is seen as being the official project document.

The framework of this document references the text of the original agreement and employs the strategies outlined in the DIP. The recommendations of the MINSAN and evolving health policy in Madagascar since the DIP are also addressed. Complying with the recommendations, the Technical Implementation Document highlights the organization and repartitions of roles between MCDI and the SSD and shows the workplans of the project for each intervention. These workplans have been integrated into the District Development Plan (PDD). A positive relationship between SSD technicians and MCDI staff has been established and a new working team has developed.

Based on the Technical Implementation Document, MCDI organized a quarterly workshop on operational planning and on the review of SSD and MCDI activities. This has prompted the SSD to assume responsibility for project activities, which are no longer seen as separate from SSD activities. SSD involvement has become active and relations have improved.

Recommendation 15: It is essential to strengthen and restructure EMAD as it remains a platform of choice for the partnership between MCDI and SSD.

Response: As for strengthening and restructuring the EMAD, MCDI has proposed an action plan for the SSD, which would include: (1) development of a new job description according to the technical responsibilities for each member (TORs) according to their workload; (2) a monitoring plan for EMAD activities and performance evaluation; (3) development of monitoring indicators (Guidelines); (4) identification of specific needs in order to execute tasks and mobilize resources; (5) strengthening team work; and (6) systematic programming of activities. SSD has begun to implement this plan since April 2001.

6.4 In Relation with Capacity Building of SSD Personnel

Recommendation 16: The notion of quality care demands a consensus between MCDI and SSD. This notion does not seem to be shared equally, and given its strong implication at all levels of the district health system, any decision must be made jointly.

Response: As far as this is concerned, the problem was resolved during a team-building workshop in March 2001. The Directors of the SSD recommended that this initiative be slowly introduced so that the personnel have a chance to familiarize themselves with procedures. It was then agreed that MCDI would first focus on quantitatively improving the care provided by CSBs, and then focus on improving general quality of care. Thus, MCDI prepared a strengthening plan that was implemented right away. This plan includes: (1) a review of the minimum level of activities offered in health centers; (2) a monitoring and follow-up plan; (3) a supervision plan, and; (4) the establishment of guidelines for activities, including programming and indicators to follow.

The project has trained Program Heads in planning, implementation, and monitoring of their individual activities.

Recommendation 17: Seize opportunities to send SSD Betioky staff to training abroad on decentralization, partnership and NGOs-public sector collaboration.

Response: Training abroad of SSD staff: No action taken (training in Dakar was cancelled).

6.5 BCC and Social Mobilization

6.5.1 The Approach

Recommendation 18: The skills of community volunteers must be strengthened further. The strengthening plan should take into account the sustainability of activities.

Response: Refresher training for VCs has been strengthened in the following areas: 1) time wise, training now occurs every two months instead of every three months; 2) training methods, which are focused primary on self-evaluation; and 3) training content, which was updated according to

the recommendations of the MTE and the introduction of new approaches, i.e. the VISA method. Health personnel have begun to take an active role in training the VCs.

Recommendation 19: Include CVAs (Cellule Villageoise d'Animation) and ASBCs in the SSD organogram so as to facilitate their integration into health development and reinforce their relationship with health personnel who should expand their activities to include Child Survival. Communes must play a major role in sponsoring VCs so as to ensure moral, institutional, and financial support for VCs.

Response: MCDI and the SSD decided that it was more logical to incorporate VCs into the organograms of the communes who play a mentoring role. The SSD would then provide technical assistance to the communes. The communes were able to air their grievances at a meeting of commune directors. Decisions made during this meeting still need to be solidified and include: (1) creation of a line item in the commune budgets for the VCs; (2) Commune management of funds allocated for the training and deployment of VCS; (3) creation, at the commune level, of a IEC & Health Unit who will manage the VCs as well as the Health and Management Committees of the health centers; and (4) training the IEC & Health Unit so that it can better fulfill its role.

Results of the meeting are still at the planning stage concerning development of a unified approach similar to that of the project.

Recommendation 20: Certain health messages should draw the attention of the project, i.e., nutrition in weaning children and mothers who breastfeed.

Response: Health messages have been jointly reviewed. A collaborative effort with the regional IEC and Health Unit has begun.

6.5.2 Capitalizing on Project Experience

Recommendation 21: Capitalize on and document the experience of the project concerning social mobilization and disseminate this information to all interested organizations.

Response: Sharing of lessons learned began with CSP presentations at each quarterly regional meeting where all of the Medical Inspectors of Toliara and DIRD Directors are present. The documentation has also begun.

Recommendation 22: Organize a regional symposium on the role of VCs and their importance in the establishment of the National Health Policy. The entire SSD and involved associations can share their experiences.

Response: During MCDI's presentation to Toliara's new managing team (Governor General and General Health Commissioner) of the CSP, the BCC and MS project approaches were well received. The Governor supported the idea that it is necessary to expand these approaches to the

entire region of Toliara. The Governor General is presently organizing a regional symposium for all implicated partners in Toliara, which aims to capitalize on all experiences gained.

Recommendation 23: Validate the intermediate services between the Public Services and the Community, such as the CVAs and the ASBCs, by allocating CS tasks as well as other, i.e., environmental education, adolescent reproductive health, community gardens, etc.

Response: Presently, the CSP still focuses mainly on child survival areas in its program with VCs.

6.5.3 Sustainability of the BCC-MS program

Recommendation 24: Institutionalize CVA and ASBC structures to safeguard acquisitions at a community level. Identify and establish revenue-generating systems for the CVAs and ASBCs to ensure the motivation and sustainability of their future activities.

Response: Since the MTE, MCDI has started identifying volunteer organizations which would become official entities. All of the functional volunteer organizations have become official, which entails the following: they have a legal status, they have internal rules, an office and revenues of their own. These organizations have all received training in organizational management (jointly with the Rural Animation Service) and start-up budget for activities, which will generate revenue (AGR). AGRs are destined to: (1) motivate organization members by including a micro-credit window for the members, using profits; (2) sustain in part the organization operational expenses (such as expenses during training or re-training). Communities have been sensitized to the need and importance of their support to this program.

6.5.4 The Inter-Sectorial Approach

Recommendation 25:

1. Ensure that the Sous-Préfecture plays a leading role in the coordination of inter-sectorial activities, such as for the CSP, in order to strengthen the synergy between partners. The inter-sectorial committee for Child Survival is already operational. But, it needs to be strengthened through increased member mobilization.
2. The S/P must formalize a platform for experience sharing and to validate approaches and results for all actors in the public and private development sectors.
3. Establish an IEC program management encompassing the entire district and mobilize all CSP partners for the launch of a social mobilization and a long-term behavior change campaign.
4. Develop a unique document defining interaction on CSP matters and follow-up this coordination with semi-annual or annual meetings.

Response: No action has been taken in this regard. A change of the directing team of the Sous-Préfecture has not allowed to go ahead with these recommendations.

7. PLAN FOR PROJECT TRANSITION

The DIP mentions that it is not MCDI's intention to transfer program responsibilities and control to other organizations since all organizations and structures, which it plans to establish, will be totally integrated in the health services delivery systems. The mid-term evaluation has identified other structures, such as the Rural Animation Directorate, the communes and other local NGOs, which have the potential to sustain project activities.

MCDI has worked until now in partnership with MINSAN, which now manages the project. The action plan, which is integrated in the district development plan, is an essential step in the strategy for project withdrawal. This has allowed for the progressive transfer of activities to SDD. The Program Heads' continued coaching with regards to project interventions has given them the necessary skills to take charge of what has been established by the project. However, this situation is being undermined by certain changes in the assignment of these Heads, especially if it is the Physician Inspector.

Members of EMAD will continue to strengthen the quality of care at the CSB level through sustained training and supervision, thanks to SSD trainers, supervisors and the various tools the project has already established. MCDI has slowly reduced its efforts in these areas in order to allow the SSD to function independently in these areas. The establishment of an information (program) tool aimed at processing data and health information for SSD management strengthens the quality of care provided to the population. The SSD currently implements this program without any further assistance from MCDI.

As far as community activities are concerned, MCDI has slowly transferred certain responsibilities to the Rural Animation Directorate (DAR) and to VEMIMA since the second year of the CSP. Therefore, the Head of DAR has worked closely with the project, as Manager of community activities. As manager, she has ensured the recruiting, training, and supervision of the health volunteers and has ensured coordination for social mobilization activities on a regional level with the Information Department. Presently, all project community activities have been transferred to and are a responsibility of DAR. Some specific technical assistance still has to be provided. On the other hand, MCDI has created a favorable environment to promote collaboration amongst the different actors of Betioky-Sud through the Inter-Sectorial Support Committee within MINSAN, in particular between DAR and SSD. Therefore, these two entities have worked together at all times. However, DAR works very closely with the local NGO VEMIMA, which has been responsible for the training of volunteers and for the follow-up of social mobilization activities. This association has grown to direct IEC promotion activities to villagers following their involvement in the project's activities.

However, it important that DAR possesses needed resources in order to continue its activities. Currently, this aspect has not yet been addressed. A negotiation with the SSD and the Inter-Regional Health Development Department could possibly resolve this problem.

Since the mid-term evaluation, the communes have been given more responsibility in handling the costs related to CVS' operation and follow-up. The communes have indeed created a credit

line spending for the volunteers and have chosen members to follow-up volunteer activities. This will allow the gradual withdrawal of CSP's support.

In regards to the child to child approach, the trainers and supervisors of the project coming from School District, as well as the program management training provided to its officials, and the implementation of tools for the follow-up of the approach, have modified the training so that the child to child approach is presently transferred to the district schooling authorities (CICSO). Only technical support (such as annual assistance for evaluation and planning) and some logistics are supported through this project.

As for community structures (association of VCS and Insurance Management Committee) their recognition and training in organizational management have given them functional independence, autonomy and their own dynamics.

In accordance with the Government strategy on the financial contribution of users to health care costs, the credit insurance scheme is presently entirely self-supporting and is managed by the community without any outside assistance. One aspect, however, remains to be considered by MCDI: the transfer of competency in management of methods and procedures to the management committee about the calculation methods and procedures to follow in case the system faces a financial crisis due to an over-utilization of credit, or inflation, or to a high rate of non-reimbursement of costs).

8. POTENTIAL FOR PROJECT SCALE-UP

Cost Extension Application

In accordance with MTE recommendations, MCDI submitted a Cost Extension Application in December 2001 for Toliary II District. The mid-term evaluation team, including personnel from MINSAN, recommended an extension of the project to the rest of Betioky-Sud District. Following this initial recommendation, the SSD solicited an expansion to Toliary II District. Therefore, MCDI proposes to expand its current child survival activities in Madagascar to encompass a broader area within the Toliary Province. The Toliary Province Child Survival Project (TPCSP) will include continuation of limited activities in the Betioky District and initiation of activities in the neighboring Toliary II District. The estimated number of target beneficiaries in the extended project area is 172,383 comprised of 97,896 WRA and 44,487 children 0-59 months during the four years of the project.

The major barriers to achieving maternal and child health in the Toliary Province are lack of access to health services, poor quality of care delivered by health services, and lack of knowledge about positive child survival behaviors. The two focus districts are the two most populated in Madagascar's poorest province, and exhibit similar epidemiological, organizational, and cultural patterns. As a result, the proposed strategies and interventions have been selected based on data from both the original CSP and external sources that define the most urgent child survival problems as diarrheal diseases, poor immunization coverage, malaria, and pneumonia. Other key problems identified include lack of exclusive breastfeeding, and extremely low use of modern contraception methods. Project interventions (and level of effort for each) are as follows:

Control of Diarrheal Diseases (15%), Immunization (20%); Malaria (15%); Pneumonia Case Management (15%); Breastfeeding (15%); and Child Spacing (20%). These interventions will be fully integrated within an IMCI framework both at the facility level and in the community (HH/C-IMCI) and are compatible with the expressed priorities of the district health authorities and key strategies of MINSAN. The Toliary II district is already receiving external support from the World Bank and African Development Bank for maternal health and nutrition interventions; therefore the TPCSP interventions relating to maternal and neonatal health will be limited and focused on activities that will best complement other initiatives without duplicating efforts.

The goal of the TPCSP is: **To reduce morbidity and mortality among children less than 5 years of age and to improve the health status of women of reproductive age (WRA) in the Betioky-Sud and Toliary II Districts.** Results-based objectives are as follows: **Pneumonia Case Management:** 1) Increase by 30% the % of mothers of children 0-23 months with fast/difficult breathing during the last two weeks who sought treatment from a health facility by the end of the day; 2) Increase by 40% the % of mothers of children 0-23 months who can identify at least two danger signs of pneumonia that indicate the need to seek treatment; 3) At least 75% of CSBs will report no stock-outs of antibiotics during the proceeding 6 months; 4) IMCI protocols will be implemented in all CSBs and used to train all clinical staff; 5) 75% of clinical staff will correctly use IMCI protocols. **Malaria:** 1) Increase by 40% the % of children 0-23 months who slept under an insecticide-treated bed net the previous night; 2) Increase by 30% the % of mothers of children 0-23 months with a febrile episode ending during the last two weeks who sought treatment from a health facility by the end of the day; 3) IMCI protocols will be implemented in all CSBs and used to train all clinical staff; 4) 75% of clinical staff will correctly use IMCI protocols; 5) Increase by 50% the percent of mothers who took anti-malarial medicine to prevent malaria during pregnancy; 6) 75% of CHVs will have a regular supply of anti-malarial medicines. **Control of Diarrheal Disease:** Increase by 30% the percent of children 0-23 months who had diarrhea in the past two weeks: 1) who were given the same or more than the usual amount of fluids during a diarrheal episode; 2) who were given the same or more than the usual amount of foods during a diarrheal episode; 3) whose mothers provide some sort of oral rehydration therapy to their child during diarrheal episodes; 4) and whose mothers sought outside advice or treatment for the illness; 5) Increase by 40% the percent of mothers with children 0-23 mos. who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending a child who has defecated; 6) IMCI protocols will be implemented in all CSBs and used to train all clinical staff; 7) 75% of clinical staff will correctly use IMCI protocols. **Immunization:** Increase by 30% the % of children 12-23 months who: 1) are fully immunized per the vaccination card; 2) and received a vitamin A dose in the last 6 months; 3) Increase by 30% the percent of mothers who receive at least two tetanus toxoid (TT) injections before the birth of their youngest child; 4) Decrease by 50% the percent of children 12-23 months who default between the DTP1 and DTP3 doses; 5) At least 50% of CSBs will have experienced no stock-outs of vaccines during the proceeding 6 months. **Breastfeeding:** 1) Increase by 30% the percent of children age 0-5 months who are exclusively breastfed; 2) Increase by 30% the percent of mothers who initiate breastfeeding within one hour after giving birth; 3) At least 75% of CSBs will provide correct information to pregnant woman on proper breastfeeding practices, LAM, and appropriate supplementary feeding practices. **Child Spacing:** Increase by 30% the percent of mothers who: 1) are not pregnant, do not want another child in the next two years or are not sure, and are using a modern method of contraception; 2)

can report at least one place to obtain child spacing/family planning services; 3) and who are presenting at a health facility for prenatal care who are screened for STIs; 4) Increase by 40% the percent of women aware of at least two ways to reduce the risk of HIV infection; 5) 75% of CBDs will have a regular supply of condoms; 6) Increase by 50% the percent of mothers who receive child spacing information during a postpartum check-up.

Major strategies to achieve the project's goal and objectives focus on (i) strengthening capacity at the community level through the development of sustainable community institutions, networks, and community-based personnel; (ii) institutional strengthening of MINSAN by improving the case management, BCC, and management/supervision skills of facility and district health personnel; and (iii) the promotion and facilitation of synergies with other donor partners on materials, training modules, equipment and materials, and the exchange of technical knowledge and lessons learned.

The TPCSP's primary partner will be the MINSAN at the Regional, District and Commune levels, including District Health Officers, district health management teams, and all local health facility personnel. In addition, the Ministry of Information, Culture, and Communication will continue to support health education/IEC initiatives, and local Ministry of Education authorities will be key partners for the implementation of child-to-child activities. The project will continue to work with local NGOs, to support community-based activities, and local academic institutions such as the Nurse and Midwife Training School and the School of Medicine to promoting in-service IMCI training. The TPCSP will also work with UNICEF in the promotion of HH/C-IMCI and support of immunization, and UNFPA in support child spacing activities. Community members are seen as both beneficiaries and partners through their involvement on committees and as partners in promoting the key family practices and emphasis behaviors. Community Health Volunteers and Community-based Distributors form the link between the community and the health center and will be the key to the HH/C–IMCI approach. In addition, a community-based management committee will help establish and run the proposed Health Credit Insurance Fund, a key to increasing access to health services. Linkages among these community-based organizations will be fostered to enhance their effectiveness.

Credit Insurance Scheme

The credit insurance scheme has experienced ample success in the Health District of Ankazomanga Ouest and it offers strong possibilities for scaling-up. It supplements the Government's health finance policy by financially assisting care users. This policy consists of cost recovering for medicines in all health centers in Madagascar. In general, the introduction of this policy has reduced use of health care since it creates a financial barrier for many users. The credit insurance scheme of Ankazamanga Ouest is trying to reduce this financial barrier through the creation of a community fund so that all members have access to short-term credit in real time according to individual needs. It has been observed that: (1) there was a substantial increase in visits to the health centers by members; and (2) a partial reduction in prescription follow-up. The system has worked well with regards to its operation, security and self-management by the community. Following this experiment, the DIRDS is presently considering to scale-up this initiative to other CSB levels, possibly soliciting future technical assistance from MCDI. This

experience with the credit insurance scheme could provide a long-term solution to MINSAN in order to strengthen its policy on resource allocation with regards to users financial participation.

Health Information System

MCDI utilizes its Excel software program to collect data generated by the monthly CSB activities' report. It is a simple and user-friendly program - any personnel having minimum computer knowledge can use it. Most SSD now have computer equipment and their staff has been trained in computer use. However, the processing of health information remains manual. Experimenting with this program has allowed the SSD of Betioky-Sud to properly manage information and archive it for later use, while raising time efficiency. MCDI proposes that this program is scaled-up to regional levels.

The VISA Approach

The VISA approach was adapted by the technical team based on a similar initiative undertaken by ADRA in Madagascar. This approach is a way to engage the community in practicing healthy behaviors and it has considerably strengthened the VCs' activities. VISA means Visit, Identify, Sensitize and Coach, corresponding to volunteers' attributes. Each VCs is asked to sponsor (i.e. take under its wing) a certain number of mothers (5 in Betioky- Sud) that he/she then trains, follow-up and supervise so that the mothers learn healthy practices to use towards their child. An example is the complete immunization of the mother's last child. The VCs is responsible for identifying behavior problems of these mothers, to sensitize and show them the benefits of behavior change, to refer them to health centers, to accompany them when they seek needed care, to visit them in follow-up and encourage them to change and/or maintain their efforts. The VCs who have met certain performance criteria are rewarded, and mothers who adhere to this approach can then be recruited as volunteers or as a member of a support group. The VCs recruit other mothers each time their protégés leave the program (either because they have learned healthy practices or have left the program). The VISA approach is complementary to the classical work of a volunteer, which is to spread health messages and promote behavior change amongst the targeted population. The VISA approach can be copied to other organizations and projects, working with volunteers such as SEECAALINE (working on community nutrition in more then 10 districts in Toliara) or ASOS (working on the development of community health and their environment in the Fort Dauphin region).

Madagascar- Action Plan FY 2002

ACTIVITIES	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02
1 - Strengthening SSD (District Health Directorate) information management												
- Improving information management system of SSD												
- Training the person in charge of HMIS (Health Management Information System) at SSD in analysis and use of data												
- Basic training of person in charge of HMIS in improved information management system												
- Publication of SSD liaison bulletins												
- Providing HMIS diffusion with computer and office automation materials												
2 - Revitalization of health centers												
- Status analysis of quality of care at the CSB (Basic Health Center) level												
- Orientation of center heads in quality of care												
- Implementation of quality of care at CSBs												
- Periodic analysis of service delivery at the CSB level												
- Monitoring												
- Supervision												
- Periodic review												
3 - Strengthening EPI division of SSD												
- Training the person in charge of EPI in cold chain maintenance and program management												
- Coaching of CSB heads in cold chain maintenance												
- Systematic analyses of needs for EPI strengthening												
- Monitoring of EPI standard indicators												
4 - Strengthening management capacities of EMAD (District Health Management Team)												
- Training of personnel in charge of management at the national and international level												
- Supporting planning and organization of activities												
5 - Increasing community participation in health development												

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ACTIVITIES	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02
- Strengthening advocacy in communities for community participation												
- Mobilize fokontany, authorities in financial, material and human contribution about health development activities												
6 - Improving the drug supply system												
- Supporting the implementation of a computerized system for drug management at the PHAGDIS level												
- Training of PHAGDIS members in information, initiation to office automation and spreadsheets												
- Basic training of PHAGDIS members in the computerized drug management system												
7 - Coordinating and strengthening training activities of SSD personnel												
- Supporting identification of SSD personnel training needs												
- Arranging training according to needs (SR, IMCI, IEC, EPI, Program Management)												
- Strengthening of health personnel's and EMAD's capacities in program management and management												
- Monitoring and refresher training of health workers in IEC, SR, IMCI, EPI, IHAB												
- Monitoring and refresher training at the communicators and community partners level in health message promotion												
- Refresher training of ASBC												
- Monitoring and refresher training of private sector partners in health message promotion												
8 - Promoting research on community insurance associations												
Improving the existing model: Credit Insurance Scheme of Ankazomanga Ouest												
Assessment of the Credit Insurance Scheme of Ankazomanga Ouest												
Capacity building of the committee members of the Credit Insurance Scheme of Ankazomanga Ouest												

Madagascar- Action Plan FY 2002

ACTIVITIES	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02
Training of persons in charge of FPU, HMIS (SSD and regions) on the Credit Insurance Scheme of Ankazomanga Ouest's credit plan						■	■	■				
- Visit to the sites of the heads of PFU and HMIS for a practical assessment							■	■				
Joint development of a monitoring plan for the Credit Insurance Scheme								■	■			
Enlarging the Credit Insurance Scheme							■	■				
9 - Assuring management of children at health centers												
- Introduction of IMCI at the health facility level					■	■	■					
- Monitoring and supervision of functional IMCI sites				■			■			■		
- Providing IMCI kits to health facilities						■	■	■				
- Strengthening of community IMCI				■	■	■	■	■	■	■	■	■
- Strengthening cooperation between VCS (Community Health Volunteers) and heads of health posts		■	■	■	■	■	■	■	■	■	■	■
- Implementation of IMCI activities jointly with the ASBCs (Community Health Agent) and community partners				■	■	■	■	■	■	■	■	■
- Orientation of community partners' training in community IHAB					■	■						
- Refresher training and orientation of health staff in IHAB				■	■	■	■	■	■	■	■	■
- Monitoring of IHAB, HAB and CSB support groups in breastfeeding promotion				■	■	■	■	■	■	■	■	■
10 - Providing immunization services for children less than one year of age												
- Supporting micro-planing of EPI activities of all health facilities				■			■			■		
- Training of new post heads about the national EPI policy				■	■	■						
11- Developing actions to fight malnutrition												
- Training of trainers in nutrition				■								
- Strengthening of VCS capacities in nutrition				■	■							
- Strengthening of AS capacities in nutrition						■						
12 - Intensify/strengthen community mobilization and communication for behavioral change												

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ACTIVITIES	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02
- Hiring and training of community relays in health facilities which don't have any												
- Strengthening of health messages promotion using a pair approach (mother-mother, father-father)												
- Strengthening of IEC material												
- Widening communication channels to include all potential communicators (traditional midwifes, traditional healers, authorities, associations)												
13 - Developing a system to motivate volunteers												
- Developing VCS capacities with regard to income-generating activities												
- Institutionalization of VCS associations (legal status)												
- Involvement of VCS in the sale of insecticide-treated bednets												
14 - Strengthening health promotion activities by schools or a child-for-child approach												
- Implementation of a rapid assessment system LQAS (Lot Quality Assurance Method)												
- Retraining of supervisors in PSE approach and interventions (AME/cholera, immunization, nutrition and oral health												
- Improving the monitoring and supervision plan of schools												
- Strengthening teachers' activities on the child-for-child approach and the PSE interventions												
- Implementation of a self-assessment system for trainers about the approach												
- Field monitoring and supervision at the school level												
15 - Implementation of the SR program												
- Orientation of EMAD on SR (finalizing MSR [Safe Motherhood] and introduction of FP clinic)												
- Introducing SR in public and private health facilities												
- Advocacy for SR: integrating authorities and men into SR												
- Training of health workers in coaching ASBC												
- Deployment of AS at sites which don't have any												

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ACTIVITIES	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02
- Training and orientation of community partners in community SR												
16- Developing training plan for MCDI personnel in Madagascar												
- Assessment of training, reorientation of DIP (Detailed Implementation Plan) budget to strengthen capacities of MCDI personnel												
17- Conducting monitoring and assessment of PSE activities												
-Final assessment												
18 - Other												
-Building upon PSE results												
-Training of trainers in the various PSE intervention fields and in the transfer of capacities												
-Strengthening health workers' capacities for coaching community partners												

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April 17, 2002

To: Benjamin Andriamitantsoa
Child Survival Coordinator
USAID Mission - Madagascar
Immeuble Vonisoa III Ave. Docteur
Ravohangy Anosy
Antananarivo, 101

From: MCDI

Date: April 17, 2002

Re: Betioky-Sud District Child Survival Project – Third Annual Activity Report

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Dear Mr. Andriamitantsoa,

MCDI is herein presenting the Third Annual Activity Report for our Betioky-Sud District Child Survival Project. The original French version was finalized and submitted to the Home Office by the end of February 2002. We apologize for the delay in presenting the Report; civil unrest in Madagascar created obstacles and affected the technical team's ability to move freely in the project zone for 3 months. BHR/PVC was informed about the situation and authorized the delay of the annual report.

In accordance with MTE recommendations, MCDI submitted a Cost Extension Application in December 2001 for Toliary II District. The mid-term evaluation team, including personnel from MINSAN, recommended an extension of the project to the rest of Betioky-Sud District. Following this initial recommendation, the SSD solicited an expansion to Toliary II District. Therefore, MCDI proposes to expand its current child survival activities in Madagascar to encompass a broader area within the Toliary Province. The Toliary Province Child Survival Project (TPCSP) will include continuation of limited activities in the Betioky District and initiation of activities in the neighboring Toliary II District. The estimated number of target beneficiaries in the extended project area is 172,383 comprised of 97,896 WRA and 44,487 children 0-59 months during the four years of the project.

The results from the Third Annual Activity Report are encouraging. The project has responded well to the recommendations outlined in the MTE and will continue to strive to meet the project objectives.

Sincerely,

Joseph Carter
Director